Eliminating Tobacco Smoke in Rhode Island Schools:

Helping Schools Enforce the Law

A Proposal Submitted to the Centers for Disease Control and Prevention

by the Rhode Island Tobacco Control Program

in Collaboration with the Rhode Island Asthma Control Program

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A Introduction to the State of Rhode Island

RI, a state of about one million people, is highly urbanized. About 85% of its population live in urban places, as defined by the U.S. census. RI has traditionally served as a port of entry to the U.S., and as such has an ethnically diverse population, with many recent immigrants from the Caribbean, from Southeast Asia, and most recently, from West Africa. Most immigrants and persons of low income have settled in five core cities, Woonsocket, Pawtucket, Central Falls, Providence, and Newport, where they reside in old wood-frame, multiple-family units. The people who live in these communities have especially high rates of asthma, compared to the rest of the State, and the State itself has a higher than average rate of self-reported asthma. ETS (environmental tobacco smoke), an important asthma trigger, has been reduced drastically in many workplaces and public places in RI, but is still a problem in middle schools and high schools, despite a state law and prohibiting smoking in these settings. To solve the chronic problem of ETS in schools, the Rhode Island Department of Health (HEALTH), in collaboration with the American Lung Association of RI, the RI Tobacco Control Coalition, the RI Asthma Control Program, and RI's Healthy Schools! Healthy Kids! Program, proposes a Smoke Free Schools Program to identify, identify, organize, and train parent advocates in 10 of 24 core city public schools (middle schools, junior high schools, and high schools) who, in collaboration with teachers, school nurses, and administration will work to eliminate ETS, the most preventable of all the asthma triggers to which children and teens are exposed.

B Definition of Population and Characterization of Need

B1 RI is an old urban state with a long-standing tobacco use problem.

Historically, smoking rates have been high in the State. In 1965, it was estimated that over 50% of adult males smoked cigarettes in RI. Although smoking among adults has declined

considerably since then, to about 23% of all adults in 1998, smoking among RI's teens has increased dramatically in the past decade. Among teens in grades 9-12, for example, the proportion who smoke cigarettes increased from about 22% in 1993 to about 34% in 1997.

RI cancer mortality, among the highest in the U.S., displays an "urban profile." In brief, Rhode Island, one of the most urban states, has higher than average cancer mortality. When this differential is decomposed, it is found to be caused by cancers of a very few sites, including cancers related to diet, such as cancers of the stomach and colon-rectum, cancers in which diet is implicated, such as cancers of the breast and prostate, and cancers related to tobacco use, such as cancers of the lung, urinary bladder, esophagus (also related to alcohol use), oral cavity, pharynx, and larynx. The mortality rates from such cancers are elevated in urban areas throughout the developed world.

B2 Asthma morbidity is higher in RI than the U.S. as a whole.

Results of RI's 1996 Health Interview Survey indicate that 72 per 1,000 Rhode Islanders self-report asthma, and 95% of those reporting asthma have been told by a doctor that they have asthma. The prevalence rate for those 18 and under was higher (87 per 1,000) than for those over the age of 18 (66 per 1,000). RI's prevalence of self-reported asthma was 33% higher than the national prevalence rate reported for 1994 (54 per 1,000).

B3 Asthma morbidity and mortality are on the rise in RI.

Analysis of hospital discharge data for the period 1991–1995 shows that while the frequency of hospitalizations due to asthma as a *primary* diagnosis remained stable, the frequency of hospitalizations with asthma as a *secondary* diagnosis increased nearly four-fold, from 118.5/100,000 to 435.2/100,000. Most of the increase was concentrated among people ages 0-44. Asthma mortality in RI has also gradually increased over the period 1972-1995.

B4 Asthma is a special problem for inner-city children and teens in RI.

Although current asthma surveillance systems were not designed to allow good small-area analysis of asthma control issues, they all point to inner city children and teens as having a larger than average asthma burden, probably caused by more than average exposure to environmental asthma triggers and less than average access to primary health care services for asthma. In response, a number of interventions have been designed in Providence, RI, the largest city in the State (16% of the total population) to increase inner-city children's access to primary health care services for asthma. Although research on environmental exposures to asthma triggers is also underway (focussing on sub-standard inner-city housing), substantive interventions have not been implemented to reduce such exposures.

B5 Environmental Tobacco Smoke is still a major problem in RI schools.

Environmental tobacco smoke (ETS) is recognized as a major environmental trigger for asthma. In RI, ETS has been reduced dramatically in most workplaces and most public places other than restaurants, and special advocacy efforts are underway to reduce ETS in the latter. RI was one of the first states in the country to pass legislation to prohibit smoking in primary and secondary schools, but the law is poorly enforced, and teens in middle schools and high schools throughout the State smoke flagrantly in bathrooms and other hideaways. Recent planning sessions conducted for the RI Asthma Control Program by the RI Tobacco Control Coalition and by the RI School Health Advisory Committee have identified ETS in schools as a preventable asthma trigger, and have suggested its elimination as an important tobacco-control / asthma-control goal for the immediate future.

B6 The policies for eliminating ETS in schools are in place, but are not effective.

In 1992, the RI General Assembly passed one of the first state laws in the U.S. to ban

smoking in schools. Rules and Regulations were written by the Department of Health to complement and specify the statute. With regard to enforcement, CHAPTER 23-20.9 of the RI General Laws, entitled "Smoking in Schools," states: "The governing body of each school in Rhode Island shall be responsible for the development of enforcement procedures to prohibit tobacco product usage by any person utilizing school facilities." Accordingly, school committees in each of the 35 public school districts in the State and the equivalent governing bodies of private schools have all developed policies to enforce the statute, and have variously enforced the statute. The result, however, has been a chronic ETS problem in middle schools, junior high schools, and high schools. The problem is not that school officials don't care about ETS in schools. They clearly do. But just as clearly, they have not been able to focus on this problem long enough to see it through to a solution. Other problems have demanded their attention first, and the ETS problem forever languishes "on the back burner," causing a significant problem for children and teens with asthma.

B7 RI needs parent advocacy to solve the ETS problem in schools.

School reform has led to the creation of School Improvement Teams (SITs) in all public schools. These cross-disciplinary teams of teachers, administrators, students, and parents are responsible for creating School Improvement Plans and implementing these plans in their school communities. Although mandated, parent involvement in these teams is difficult to accomplish, and recruiting parents who care about heath issues is often difficult.

School officials with whom HEALTH staff have discussed the ETS problem all firmly agree on one point. With active parent involvement, the problem will be solved. Without it, the problem will persist. Also, parent involvement needs to be local. It needs to be felt in every secondary school. Every secondary school needs a parents advocacy group to focus attention on

the ETS problem, and to assist school administrators, school nurses, and other faculty members in solving it. Exploring solutions to the ETS problem will inevitably involve parent advocates in other essential tobacco control issues, like youth access to tobacco, and the need for accessible, youth-oriented tobacco cessation programs.

B8 The need is greatest in RI's five core cities. Work in Year 1 should start there.

The need for asthma control is greatest in RI's five core cities, where asthma incidence rates are higher than elsewhere, and where children of low income families have difficulty accessing primary health care services for asthma. It is here that RI's newly-funded (CDC-sponsored) Asthma Control Program will concentrate its efforts, and here that RI's Tobacco Control Program has invested heavily in bringing tobacco control interventions to low-income minority populations.

HEALTH is already very involved in the secondary schools of the core cities through its promotion and sponsorship of School Based Health Centers (SBHCs). RI's goal is to have SBHCs in all core city high schools. Four existing SBHCs provide direct health care services to students but also serve to heighten the awareness of health issues in their schools through caring health professionals who take a holistic approach to health problems.

We propose to focus work in Year 1 on organizing parent advocacy groups in 5 out of the 14 public middle and junior high schools and 5 out of the 10 public high schools of RI's five core cities. With one-year's special funding for this purpose, we believe we can jump-start parent advocacy groups in the core cities strongly enough that they will persist, supported and maintained with core tobacco control resources from the State of RI in the future. In Years 2 and 3, using State support, we would continue organizing parents' groups in the five core cities. In Years 4 and beyond, we would bring this work to other municipalities, starting with those places

with the largest numbers of low-income families.

C Plan for Parent Advocacy in Core City Schools

C1 Summary of Plan Contents

- C2 Vision
- C3 Mission
- C4 Essential partners
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C2 *Vision*

Smoke-free core city schools, friendlier to children with asthma.

C3 *Mission*

To identify, identify, organize, and train parent advocates in 10 out of 24 core city public schools (5 out of 14 middle schools and junior high schools, and 5 out of 10 high schools) who, in collaboration with teachers, school nurses, and administration will work to eliminate ETS, the most preventable of all the asthma triggers to which children and teens are exposed, and to support related tobacco control activities in the schools.

C4 Essential Partners

- **The American Lung Assiciation of RI (ALARI):** The organization that owns asthma control issues in the state, and a longstanding collaborator on tobacco control issues. Especially strong in advocacy, and familiar with core-city schools, ALARI will guide the proposed Smoke Free Schools Program as part of its management structure, assuring appropriate use of American Lung Association educational and advocacy materials.
- **The RI Tobacco Control Coalition (TCC):** A strong, diverse group dedicated to tobacco control, with a special, proven interest in low income and minority teens. With very strong connections throughout RI's five core cities, the TCC will guide the proposed Smoke Free

Schools Program as part of its management structure, assuring essential community linkages and the backing of very important minority advocacy groups.

- **The RI Asthma Control Program (ACP):** A newly organized program working to write a statewide Asthma Control Plan and to coordinate a variety of strong asthma interventions already underway in RI. The ACP (in which ALARI and HEALTH collaborate) will guide the proposed Smoke Free Schools Program as part of its management structure, assuring coordnation with other asthma control efforts, and appropriate use of asthma control information and materials.
- **RI's Healthy Schools! Healthy Kids! Program (HS!HK!):** A mature, statewide school health program (in which HEALTH and the RI Dept of Education collaborate), with excellent ties to school nurse teachers in the State. Hs!HK! will guide the proposed Smoke Free Schools Program as part of its management structure, assuring coordination with other school health programs and helping maintain good relationships with school personnel at all levels.

C5 Staffing

The proposed Smoke Free Schools program will be staffed by one full-time School Advocacy Coordinator, based at HEALTH, and supervised by the Program Manager of the RI Tobacco Control Program. The Coordinator will be hired as a contract employee by HEALTH to assure a very early start date.

C6 *Management*

The proposed Smoke Free Schools program will be managed by the Program Manager of the RI Tobacco Control Program with the guidance of a Smoke-Free Schools Collaborative consisting of one representative from each of the essential partners, above. The Collaborative

will meet monthly to assure the smooth operation of this "jump-start" program. The RI Tobacco Control Program (to which the RI Tobacco Control Coalition provides oversight), the Healthy Schools! Healthy Kids! Program, and the RI Asthma Control Program are all based in HEALTH's Division of Disease Prevention and Control. Dr. Fulton, who heads the Division as an Associate Director of Health (and who serves as P.I. of the Asthma Control Program), will provide special oversight to the functioning of the proposed Smoke Free Schools Program, to assure the proper coordination of HEALTH staff for this important program.

C7 Objectives, activities, responsible parties, time line, evaluation indicators

Please refer to Table 1, ANNUAL ACTION PLAN: RI Smoke Free Schools Program, 1 June 2000 – 31 May 2001, page 12.

D Program Sustainability

The Smoke Free Schools Program has been designed as a one-year pilot to test the feasibility of identifying, organizing, and training parents in core city middle, junior high, and high schools as advocates for clean indoor air and related tobacco control programs. If the model proves to be successful, the RI Tobacco Control Coalition (TCC) will consider supporting the program with state tobacco control funds. There are a number of strong reasons for doing so:

- The Program addresses a chronic problem on the TCC's agenda: widespread ETS in schools despite state law, regulations, and organizational policies banning smoking indoors.
- The Program provides an excellent liaison with the newly organized Asthma Control Program and its growing network of clean-air advocates.
- The Program helps build a sustainable tobacco control presence in schools. It is designed to foster the cooperation and investment of school officials, who may eventually be drawn into the network of tobacco control advocates in the State.

- The Program provides a large cadre of new tobacco control parent-advocates, whose support may transfer from smoke free schools to other essential tobacco control issues relevant to youth and teens in middle, junior high, and high schools.

The TCC will be supported in this endeavor by all the partners in the proposed Program, because continuing a successful pilot is of great interest to all:

- For asthma control advocates networked by the Asthma Control Program, the Program provides an organized asthma control presence in core city schools (and in other schools, as the program is disseminated). The cooperation between parents and school officials developed by the program may be used to foster better self-management of asthma in the school setting.
- For school health advocates in the Healthy Schools! Healthy Kids! network, the Program builds grass-roots parent advocacy in key schools for essential school health programs. Thus far, HS!HK! has been successful in building support from school officials. Organized cadres of parent advocates would move the entire HS!HK! effort to a new level of development.
- For the American Lung Association of RI, the Program provides an advocacy base in schools for the elimination of ETS, for the prevention and cessation of tobacco use among teens, and for the development of “asthma-friendly” physical and social environments in schools.

The TCC provides the glue that will hold the coordinated advocacy for this program together. The Asthma Control Program, HS!HK! and ALARI are all members of the TCC’s executive committee, and as such, meet regularly (usually, monthly) to discuss tobacco control policy in the State, providing oversight for all publicly-funded tobacco control programs in RI. The TCC also includes very active representation from RI’s four major racial and ethnic minority groups, Hispanics, African Americans, Southeast Asians, and Native Americans, whose children make

up a large proportion of all school students in the five core cities. The public health community in RI is a tight one, and the professionals who represent the essential partners (TCC, Asthma Control Program, HS!HK!, and ALARI) have collaborated with one another since at least 1991, the year RI received major federal funding for tobacco control. In addition, the TCC has fought hard to make itself inclusive of RI's minority populations, and with them as full partners has invested significantly in each of the four major minority communities in the State.

In summary, the key stakeholders are sitting around the same table, and have collaborated successfully for almost a decade. All have excellent reasons to support the Smoke Free Schools Program, and all will participate in the process of managing and supporting it, right from the start. The Program, if successful, will be sustainable on State funding, supplemented by significant, practical, in-kind contributions from the key stakeholders.

E Budget and Justification

Salary and wages	Contract Employee / GS. 24 = $17.35 + Fringe @ $3 = $20.35 x 35 x 52)	$37,040

The School Advocacy Coordinator will conduct all the work proposed above, supervised by the Program Manager of the RI Tobacco Control Program. The Coordinator will be hired as a contract employee by HEALTH to assure a very early start date.

Supplies		$1,500
Telephone	$1,000 is budgeted per year per FTE	$1,000
Office Supplies	$ 500 is budgeted per year per FTE	$500
Travel/Conferences		$3,000
Out of state	One trip to the CDC in Atlanta; airfare + 3 nights	$1,000
	One local conference; mileage + 2 nights	$450
In state	5000 miles @ $0.31 / mile	$1,550

Meeting costs		$1,863
Substitutes	25 substitute teachers @ $50	$1,250
Materials	200 packets @ $2 / packet	$400
Other expenses		$213

The hiring of substitute teachers will be necessary to cover the time of school nurse teachers at meetings planned for the proposed program.

Direct Cost Totals		$43,403
Indirect Cost	15.2% x 43,403 = $6,597	$6,597
TOTAL		**$50,000**
Matching contributions		**$5,409**

Dr. Fulton, PI of HEALTH's Asthma Control Program, and Associate Director of the Division in which the Asthma Control Program, the Tobacco Control Program, and the Proposed Smoke Free Schools Program are or will be based, will contribute $5,409 in kind, (state-funded salary and fringe for 5% FTE) for oversight and coordination of these programs.